BHSF Form 148-W
Rev. 04/10
Prior Issue Obsolete

Notification of Admission, Status Change, or Decertification/Discharge for HCBS Waiver

Support Coordinator/ADHC Agency:		Medicaid Provider #:
Support Coordinator/ADHC Address:		Region #:
Telephone #:	Fax #:	Parish:
Waiver: ☐NOW ☐ Children's Choice ☐ EDA ☐ ADHC ☐ Supports Waiver ☐ ROW		

I. PARTICIPANT/MEDICAID ELIGIBLE INFORMATION

A. Participant's Name:		SSN:	Parish:
Address:			Telephone #:
Sex: : ☐M ☐F	DOB:	Marital Status: ☐Single ☐Married ☐Widow ☐Divorced/Separated	
Medicare #:	Medicaid Eligible? ☐Yes ☐No	Medicaid#:	
B. Personal Representative/Curator:			Relationship:
Address:			E-mail:
Home Phone:	Cell Phone:		Daytime Phone:

II. ADMISSION INFORMATION

A. ☐ADHC Admission Date:	☐Program Linkage Date (all other waivers):	
B. Residence Prior to Admission to HCBS: (Specify from Section V):		
C. Intended Admission Payment Source: ☐Medicaid ☐ Other (specify):		
D. ☐Received as a transfer on date:	from Parish:	
E. ☐Received as a transition from the	Waiver to the	Waiver, on (date):

III. STATUS CHANGE (Includes Transfers)

A. ☐On temporary leave from waiver but not discharged, effective LTC date: _____ (Not to exceed 90 days) Temporary Placement (Facility Name): _____ Facility Type: ☐Nursing Facility ☐ Public ICF/DD ☐ Private ICF/DD ☐ Other:_____ If transferred from acute care hospital to temporary placement in LTC facility, indicate acute care hospital admit date:_____		
B. ☐Returned to waiver from temporary placement, effective date:		
C. ☐Transferred from Parish:	to Parish:	on date:
D. ☐Transitioned from the	Waiver to the	Waiver on date:
E. ☐Transferred from	Agency to	Agency on (date):

IV. DISCHARGE or DEATH NOTICE (Permanent Discharges Only)

A. Discharged to (from Section V, include address): _____ Reason for Discharge: _____		Date of Notice from DHH RO to Discharge: _____
B. Date of Death:		

V. SOURCE OF ADMISSION or DISCHARGE DESTINATION

1. Own home (specify address)
2. Apartment (specify address)
3. Family member's home (specify name & address)
4. Friend's home (specify name & address)
5. A Nursing Facility (specify name & address)
6. General hospital (specify name & address)
7. Psychiatric hospital/unit (specify name & address)
8. Rehabilitation hospital (specify name & address)
9. A residential program or group home (specify name & address)
10. An ICF/DD (specify name & address)
11. A Medicare distinct unit (specify name & address)
12. Hospice (specify name & address)
13. Incarceration (jail/prison/detention center)
14. Other (specify)

_____ _____

Support Coordination or ADHC Representative **Date**

_____ _____

Approving DHH Waiver Representative (Section IV ONLY) **Date**